READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

PRIVACY ACT STATEMENT

AUTHORITY: P.L. 104 -106, National Defense Authorization Act for FY 1996; and E.O. 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

PRINCIPAL PURPOSE(S): The form is used to record personal and other applicable information needed to enroll or decline enrollment in a program of insurance to protect against income loss resulting from involuntary recall to active duty (other than for training) for more than 30 days.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish requested information will result in the individual not participating in the insurance program.

WHAT THE MEMBER SHOULD KNOW

This insurance is granted under the Ready Reserve Mobilization Income Insurance provisions of title 10 United States Code, Chapter 1214, and is subject to the provisions of that title and its amendments, and regulations promulgated thereto.

Covered Service. Active duty (AD) performed by a member of a Reserve component under an order to AD for a period of more than 30 days. The AD order must specify that the member's service is involuntary and in support of an operational mission; or in support of forces activated during a period of war or national emergency declared by the President or Congress.

Entitlement to Benefits. An insured member shall be entitled to payment of a benefit for each month (and fraction thereof) of covered service that exceeds 30 days of covered service, except that no member may be paid a benefit for more than 12 months during any period of 18 consecutive months. Proof of loss of income or expenses incurred as a result of covered service is not required.

Insufficient Assets. If assets are insufficient to pay benefits the Secretary will request the President to submit to Congress a request for a special appropriation to cover the insufficiency. If an appropriation is not made, the Secretary will reduce the amount of benefits paid to a total amount that does not exceed assets of the Fund by the end of the fiscal year. Benefits not paid because of such reduction will be deferred and may be paid only after and to the extent that additional funds become available.

INSTRUCTIONS ON COMPLETING THIS FORM

1. Type or print in ink all items except where otherwise noted.

2. BENEFICIARY(IES)/DESIGNATED RECIPIENT(S) (B/DR(s))

A. A new election form must be completed to change your B/DR. You may name a spouse, child, parent, heir, or other person with an insurable interest (i.e., business partner, friend, etc.). In addition, you may direct that payments of benefits be deposited with a bank or other financial institution to the credit of the B/DR. If no such designation is made, and the member is deceased, upon establishment of a valid claim the amount will be payable in accordance with the laws of the State of the member's domicile.

B. If the B/DR is a married woman, use her own first and middle names. For example, use Mary Lisa Smith, instead of Mrs. John Smith.

C. A named B/DR will **NOT** be changed automatically by any event occurring after you complete this form (e.g. marriage, divorce, etc.). Your B/DR cannot be changed by, and is not affected by, any other documents, such as a divorce decree or will.

D. If you name minor children as B/DR(s), the insurance will be paid to the court-appointed guardian of the children's estate.

3. SOCIAL SECURITY NUMBER

Do not delay completing this form if you do not have a B/DR's Social Security number. The Social Security number helps us to locate the B/DR, but it is not necessary.

4. SHARES TO EACH B/DR

If you name more than one B/DR, the sum of the shares must equal 100%, or the full dollar amount of your insurance.

Example:						
	mother	$500		50%		1/2
	father	$500	or	50%	or	1/2
	Total	$1,000		100%		1

5. PROVISIONS FOR PAYMENT OF INSURANCE

A. If you name more than one principal B/DR and one or more predeceases you, the share(s) will be divided equally among the remaining principal B/DR(s), unless otherwise stated. If there are no surviving principal B/DR(s), the proceeds will be divided among the contingent B/DR(s).

B. If you do not name a B/DR, or if there are no surviving B/DR(s), or if you indicate that payment should be made by law, the proceeds will be paid in the following order:

1. Widow or widower.
2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child).
3. Parent(s) in equal shares or all to surviving parent.
4. A duly appointed executor or administrator of your estate.
5. Other next of kin.

6. WHAT YOUR B/DR(S) SHOULD KNOW

To establish a valid claim, your B/DR(s) should send a claim to the member's Military Service.

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(Please read the Privacy Act Statement and Instructions before completing this form.)

1. USE THIS FORM TO: *(X all that apply)*

- [ ] a. Name, change or update your beneficiary
- [ ] b. Increase the amount of your insurance coverage
- [ ] c. Reduce the amount of your insurance coverage
- [ ] d. Decline insurance coverage **(IRREVOCABLE)**

IMPORTANT: This form is for use by members of the Ready Reserve. This form does not apply to and cannot be used for any other Government Insurance.

2. NAME *(Last)* *(First)* *(Middle)*	3. RANK, TITLE, OR GRADE	4. SOCIAL SECURITY NUMBER

5. BRANCH OF SERVICE *(Do not abbreviate)*	6. CURRENT DUTY LOCATION

7. AMOUNT OF INSURANCE

By law, you are eligible for the basic benefit of $1,000. If you want $1,000 of insurance, skip to Item 8, "Beneficiary(ies)/Designated Recipient (B/DR) and payment Options." ***If you want less than $1,000 of insurance***, please mark (X) block a. below and write the amount desired and your initials. Coverage is available in the following amounts: $500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500, or $5,000. ***If you want additional coverage*** above the $1,000 amount, mark block a. and write in the exact amount desired in $500 increments up to the maximum amount allowable. ***If you do not want any insurance***, mark block b. below and write (in your own handwriting), "I do not want insurance." Actual benefit amounts are subject to periodic adjustment.

- [ ] a. I want coverage in the amount of $ _____. Your initials: _____
- [ ] b. *(Write "I do not want insurance.")*

NOTE: Once enrolled, you may reduce the amount or stop your participation at any time. However, you cannot increase your coverage. A decision to decline coverage or terminate your enrollment is generally irrevocable.

8. BENEFICIARY(IES)/DESIGNATED RECIPIENT (B/DR) AND PAYMENT OPTIONS

I designate the following person or entity to receive payment of my insurance proceeds. I understand that the principal B/DR(s) will receive payment upon my death. If a designation is not made, a valid claim will be payable in accordance with laws of the State of the member's domicile.

COMPLETE NAME *(first, middle, last)* **OF EACH BENEFICIARY** **a.**	**ADDRESS** *(Street, Apartment No., City, State, and ZIP Code)* **b.**	**SOCIAL SECURITY NUMBER** *(if known)* **c.**	**RELATIONSHIP TO YOU** **d.**	**SHARE TO EACH BENEFICIARY** *(Use %, $ amounts or fractions)* **e.**
BENEFITS WILL BE PAID TO:				
(1)				
(2)				
PRINCIPAL B/DR				
(1)				
(2)				

9. I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM. I ALSO UNDERSTAND THAT:

- ***This form cancels any prior beneficiary/designated recipient or payment instructions.***
- The proceeds will be paid to B/DR(s) as stated in Paragraph 2 of the instructions, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- Maximum coverage amount available as of this date is $ _____. Your initials: _____

a. YOUR SIGNATURE *(Sign in ink. Do not print.)*	b. DATE

10. *(Do not write in space below - for official use only.)*

a. WITNESSED AND RECEIVED BY	b. RANK, TITLE, OR GRADE	c. ORGANIZATION	d. DATE RECEIVED

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- [ ] a. I want coverage in the amount of $ _____. Your initials: _____
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COMPLETE NAME *(first, middle, last)* OF EACH BENEFICIARY a.	ADDRESS *(Street, Apartment No., City, State, and ZIP Code)* b.	SOCIAL SECURITY NUMBER *(if known)* c.	RELATIONSHIP TO YOU d.	SHARE TO EACH BENEFICIARY *(Use %, $ amounts or fractions)* e.
BENEFITS WILL BE PAID TO:				
(1)				
(2)				
PRINCIPAL B/DR				
(1)				
(2)				

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BENEFITS WILL BE PAID TO:				
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(2)				

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DIRECTIONS TO PERSONNEL CLERKS OF THE MILITARY SERVICES

1. Complete all appropriate items on the election form. All entries, except the signature and those requested to be in the member's own handwriting, must be typed or printed in ink. An original and at least one copy, which are the official copies, must bear an original signature of both the member and the witness.

2. Make sure the name(s) of one or more principal B/DR(s) appear in Item 8, "Beneficiary(ies)/Designated Recipient (B/DR) and Payment Options", if desired. Include the address and Social Security number, if available, for the B/DR(s) and their relationship to the member (e.g., father, sister).

3. An authorized agent of the Military Service must witness the signature of the member. This representative must sign his or her name below that of the member and should put the date he or she signed the form.

4. This form, properly executed, is authority to a payroll office to change the deductions for insurance premiums or to not make such deductions, if the amount of insurance is changed or cancelled.

5. Inform all members that if they have questions about this form that they may obtain the advice of a military attorney at no expense to the member.

6. Disposition of copies: Reproduce official copies before signing and circle distribution on bottom right of form. Wording and format of form may not be altered. Forms altered from the original wording or format are subject to acceptance by the Military Service.

Copy 1 - Must be promptly filed in the official personnel file of the member.

Copy 2 - To member. Certificate of coverage.

Copy 3 - **FOR USE BY THE RESERVE COMPONENT OF THE MILITARY SERVICES**